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Summary

¶1. Summary. Every two weeks, Embassy Pretoria publishes a public health newsletter highlighting South African health issues based on press reports and studies of South African researchers. Comments and analysis do not necessarily reflect the opinion of the U.S. Government. Topics of this week's newsletter cover: Children's Bill Approved by NCOP; Resignations of South African AIDS Experts; South African Study Reports High Mortality Rate Waiting for Treatment Upon Enrollment; New Study Highlights Social Costs of AIDS on South Africa; Malaria Cases Reported in Limpopo Province; and Initial Human Trials May Start to Test AIDS Herbal Treatment. End Summary.

Children's Bill Approved by NCOP

¶2. The National Council of Provinces (NCOP) has approved the first section of the Children's Bill that will outlaw virginity testing and male circumcision under the age of 16, both controversial issues provoking much cultural debate within South Africa. The Bill allows virginity testing for girls over the age of 16, if they have proper counseling, that the results are not publicized and that the girl's body is not marked. Male circumcision was also forbidden unless the boy is 16 years or older and receives counseling, or is for religious or medical purposes. Once the bill becomes law, anyone who performs a virginity test or a circumcision on a child under the age of 16 could face legal action. Earlier in 2005, when the Children's Bill was passed by the National Assembly, virginity testing was banned, while male circumcision was not. The National Assembly's decision to ban virginity testing raised concern from the National House of Traditional Leaders, which deemed it a violation of cultural rights. The NCOP amended the National Assembly's decisions to allow some testing and circumcision.

¶3. Under the new bill, a child can consent to medical treatment, including HIV testing and the purchase of contraceptives, at 12 years of age. Previously, under the Child Care Act, the minimum age had been 14.

¶4. There are contradictions in the new bill. Having sex with a child aged 15 or younger is considered statutory rape, but the new law assumes a 12-year-old is mature enough to purchase

condoms. Another concern is that, at 14 years old, children can now consent to surgical procedures, including abortion. However under the new bill, a girl can consent to giving up her baby for adoption only at 18, whereas previously, a 16-year-old could make that decision. The Children's Bill updates the Child Care Act of 1983 and amends a section of the Bill of Rights that refers to children. It is divided into two sections: section 75 and section 76. Section 75 focuses on provisions for children while section 76 will concentrate on Child Welfare services. Section 76 will be presented before parliament in 2006. New features of the Children's Bill include: (1) establishment of a National Child Protection Register, which will allow all employers to check whether their employees are suitable to work with children; (2) barring anyone who has been found guilty of an offence against children to work in an environment that involves children; (3) establishment of a Register of Adoptable Children and Prospective Adoptive Parents, aiding social workers in matching children and adoptive parents; and (4) allowing children to remain with their siblings under the care of an adult designated by the court. Source: The Star, December 24 2005.

Resignations of South African AIDS Experts

¶5. Fareed Abdullah has resigned from his position as deputy director-general of health of the Western Cape AIDS department, and will begin a three-year job at the International HIV and AIDS Alliance, based in Brighton, England. Abdullah has been responsible for the province's HIV and AIDS program for 11 years during which he played a crucial role in expanding access to anti-retroviral therapy (ART) and prevention of mother-to-child HIV transmission program, which has seen a reduction of the transmission rate from mothers on ART from 30% to 5%. As

head of the International HIV and Aids Alliance's technical division, Abdullah will be in charge of program design and evaluation in 20 developing countries most of which are in Africa. Earlier in December, Dr. Chris Jack, head of the HIV/AIDS program in KwaZulu-Natal resigned to work as a consultant in Durban. KZN officials recently announced that Dr Busi Nyembezi would be the new head of the province's Health Department, following the retirement of Professor Ronald Green-Thomson as the Superintendent-General. Source: The Cape Times, January 9; Sunday Times January 8 2006.

South African Study Reports High Mortality Rate Waiting for Treatment Upon Enrollment
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¶6. A prospective operational study of a community-based antiretroviral treatment (ART) program in Cape Town, South Africa has reported a very high rate of mortality among patients waiting to go on treatment after enrolling. According to the study, published in AIDS in December 2005, nearly half of the observed deaths occurred in patients who had recently enrolled in the ART program but who were not yet on treatment. The vast majority of deaths occurred in patients with CD4 cell counts below 50 and advanced symptomatic disease (WHO stage 3 and 4). A number of studies have previously reported on the survival benefit observed after the ART rollout in resource-limited settings, but this is the first to report on the mortality rates among patients during the time between enrollment into the program and the actual start of treatment.

¶7. The trial, conducted at the Gugulethu Community Health Centre on the outskirts of Cape Town between September 2002 and February 2005, involved 712 patients referred to clinic for ART. After referral to the ART service, patients had to make at least three visits to the clinic before they could actually receive treatment. Of the 712 patients included in the analysis, the median CD4 count was 94 cells and the median plasma viral load was 72 349 copies/ml. The vast majority of patients had advanced disease, WHO clinical stage 3 for 354 (50%) and stage 4 for 215 (30%).

¶8. A total of 578 patients (81%) started ART, a median of 29 days after enrollment (96% within 90 days). The most frequent reasons that the remaining 134 patients (19%) did not go on ART were 1) death, 2) decision to access treatment elsewhere, 3) failure to attend follow-up clinic appointments, 4) moving out of the area and 5) psychosocial reasons, such as denial of HIV infection status. The median period of observation for the patients who didn't go on ART was 28 days. Sixty-eight (9.5%) of the patients who enrolled into the program died during the course of the study. The high mortality rate of 35.6 deaths/100 person years before treatment fell to 2.5/100 person-years at one year among those on ART. Within the first three months of enrollment, 29 of 44 (66%) deaths occurred among patients not yet on ART.

¶9. The authors suggest that reducing pre-treatment intervals may well decrease mortality. However, a balance needs to be established between minimizing the pre-treatment interval (potentially reducing early mortality risk) and allowing adequate time to prepare patients for treatment (promoting high rates of treatment adherence and reducing long-term mortality rates). They also suggest that a fast-track system could be developed to speed treatment of patients at the highest risk of death (those with stage 4 disease, a CD4 count < 50 cells/ml or an AIDS-defining illness). Source: AIDSMAP December 23, 2005, AIDS. 19(18): 2141-2148, 2005.

New Study Highlights Social Costs of AIDS on South Africa

¶10. The Center for the Study of AIDS, at the University of Pretoria, published a new report, "Buckling: The impact of AIDS in South Africa", by South African writer and journalist Hein Marais. Marais presents an alternative analysis of AIDS impact in South Africa, and proposes a minimum social package to reduce the damage. According to Marais, most projections of how the AIDS epidemic will affect society are vastly oversimplified and policies based on conventional conceptions of the societal effects of AIDS are likely to fail, or may even further aggravate existing inequities. Marais argues that

analysis of AIDS' impacts has to explicitly take into account South Africa's economic and social inequities as well as the interplay of the epidemic with local resources and existing social arrangements. Marais argues that the least privileged sections of society will disproportionately bear the brunt of the AIDS and that this could undermine South Africa's attempts to become a more just and equitable society, deepening the structural crisis in South Africa which is already fuelling the epidemic. He calls on South Africa to improve its social security net by developing a comprehensive package of social services including job creation and workers' rights protection, safe-guarded food security, and the affordable provision of essential services. "Overcoming the epidemic," writes Marais "therefore coincides with the overarching need to bring about a much more just society, one in which all South Africans have at least the basic means to a secure livelihood and the realistic prospect of improving their lives and those of their children." Source: AIDSMAP, December 23, 2005.

Malaria Cases Reported in Limpopo Province

¶11. Over 100 cases of malaria were reported in Limpopo Province in 2005 with 53 reported cases since December, despite South Africa's aggressive malarial control programs. The recent increase in malaria has been attributed to increased rains providing stagnant pools of water. South Africa sprays DDT in the affected areas, with the last Limpopo spraying in September and October 2004. In the past several years, most of Limpopo districts have experienced drought conditions. National Health officials are meeting with their provincial health counterparts to discuss anti-malarial measures. Source: City Press, January 8, 2006.

Initial Human Trials May Start to Test AIDS Herbal Treatment

¶12. An herbal mixture, known as Ubhejane, may become the first traditional medicine to be tested on humans. Pre-clinical tests on the safety and activity against bacteria and fungi were conducted by the University of KwaZulu-Natal's Nelson Mandela School of Medicine and human trials on its efficacy are scheduled to begin at the end of 2006. Dr. Nceba Gqaleni of the Nelson Mandela School said that Ubhejane had a `potent activity' against opportunistic infections associated with HIV/AIDS and is currently conducting a second phase metal analysis and antiviral tests with the compound, due to be completed in April 2006. Up to 80 herbs collected throughout Africa composes Ubhejane. Individual instances of improvement in CD4 counts and reduction in viral loads have been documented in patients using Ubhejane; however, the Medical University of South Africa's Patrick Maduna emphasized the need for more research before any more favorable expectations were created. Source: City Press, January 8.

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